VITALE
Ear, Nose & Throat

VITALE ENT NEW PATIENT REGISTRATION

Patient Name	**Date of Birth**	**How did you hear about our office?**
Patient Address	**Patient Phone Number**	**Preferred Language**
Ethnicity/Race	**Marital Status: Married Single Divorced Widowed**	
Email Address	**Primary Care Physician**	**Pharmacy & Phone Number**
EMERGENCY CONTACT (NAME, RELATION, PHONE NUMBER)		

CONSENT TO TREAT

I hereby give my consent to all physicians and healthcare staff of Vitale Institute P.L. to provide medical treatment as deemed necessary.

Release of Information:

I hereby authorize Vitale Institute P.L. and staff to obtain all necessary medical records from other doctors' offices, hospitals, clinics, surgery centers, and laboratories. I hereby give my consent to use my individual identifiable information as needed in the course of routine healthcare operations. I hereby authorize Vitale ENT to release any and all information to secure reimbursement from any insurance company to which I have subscribed.

Assignment of Benefits:

I hereby contest to allow a photocopy of my signature to be valid as the original, in order to process my current and any future Insurance claims. I hereby assign insurance benefits to be paid directly to Vitale Institute P.L.

Signature of Patient or Guarantor: _____ **DATE: / /**

ASSIGNMENT OF INSURANCE BENEFITS

Your insurance policy is a contract between you and your insurance company. Vitale ENT cannot guarantee payment of your claims. You alone are responsible for negotiating claims with your insurance agency. As a courtesy we will be happy to help you determine coverage you have available. In addition, Vitale ENT will be happy to request referrals/authorizations as needed, but ultimately, is the responsibility of the patient.

I hereby assign all medical benefits, to include major medical benefits which I am entitled, private insurance, and any other health plans to Vitale ENT. A photocopy of my insurance card is considered valid and original. I am financially responsible for all charges not paid by insurance or for any charges relating to self-pay. I hereby authorize Vitale ENT to release all information necessary to secure payment. If the insurance pays only a portion of the bill or fails to make payment to Vitale ENT within 120 days, I will be responsible for the balance in full at this time.

Signature of Patient or Guarantor: _____ **DATE: / /**

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Zephyrhills: 6310 Fort King Rd 33542
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnosis, and treatment, any plans for future care or treatment and payment for the services we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", MAY WE USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultations with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or health care.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your healthcare and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment provided to you.
- To leave appointment reminders or other minimal necessary information related to your healthcare or healthcare payments on your answering machine, your mobile voicemail or with a household family member.

  □ **Please check**, if you do NOT want us to leave messages on your answering machine or with household family members.

  □ **Please check**, if you do NOT want us to leave messages on your cell phone voice mail.
- To discuss your health or payment information (only the minimal necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- You may request a copy of our "*Notices of Patient Privacy Practices*", at any time that provides a more complete description of health information uses and disclosures as required by the HIPAA standard.
- You have read or have had the right to read the "*Notices of Patient Privacy Practices*" prior to signing this authorization.

If you choose, please list by name and relationship the persons with whom we may share your healthcare or financial information with (SPOUSE, PARENT, CHILD, ECT):

- **Name: _____ Relationship: _____**
- **Name: _____ Relationship: _____**

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Signature of Patient or Guarantor: _____ DATE: / /

APPOINTMENT NO SHOWS

Vitale ENT request that if you need to cancel or reschedule your appointment, you do within the same day as your scheduled appointment. Failure to cancel may result in a **$50 dollar no show fee.** Office procedures, surgeries, and allergy testing must be cancelled **24 hours prior to appointment. Failure to do so will result in a $100-dollar fee. ***This fee is not covered by your insurance. *****

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STANDARD AUTHORIZED USE OF DISCLOSURE OF PROTECTED HEALTH INSURANCE INFORMATION

PRINT, SIGN, DATE BELOW- LEAVE TOP PART BLANK

Information to be used/or disclosed: OFFICE USE ONLY

_____Complete Medical Records

_____Medication List

_____ Problem List

_____ Diagnostic Imaging / Lab Results

_____ Office Visits

_____ Other Results/Reports: _____

Authorized to Disclose Information: (OFFICE USE ONLY)

_____ _____
Name of Person or Organization Phone Number

_____ _____
Address Fax Number

Person to Whom Information May be Disclosed:

Vitale Institute P.L.
NPI: 1073559936
27516 Cashford Circle, Suite 101
Wesley Chapel, FL 33544
Phone: (813) 406-4400
Fax: (813) 929-6633

Expiration Date of Authorization
This authorization is effective through _____/_____/_____, unless revoked or terminated by the patient or the patient's representative.

Right to terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Vitale Institute P.L. You should contact the medical records department to terminate an authorization.

_____ _____ _____
Print Patient Name Patient/Guardian Signature Date

FOR OFFICE USE ONLY: **PLEASE FAX RECORDS TO 813-929-6633**

PATIENT NAME & DOB: _____

FAXED BY: _____

DATE:_____

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ARBITRATION AGREEMENT FOR CLAIMS ARISING OUT OF OR RELATED TO MEDICAL CARE AND TREATMENT

ARBITRATION PROCEDURES: The parties agree and recognize that the provisions of Florida Statues, Chapter 766, governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Florida Statues,766.106 or 766.207, the parties and/or claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Accordingly, any demand for arbitration shall not be made until the conclusion of the pre-suit screening period under Florida Statues, Chapter 766. Within (20) twenty days after a party to this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy, the parties to the dispute or controversy shall each have an absolute an unfettered right to appoint an arbitrator of its choice and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection of the neutral arbitrator. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. The parties agree that the arbitration proceedings are private, not public, and the privacy of the parties and of the arbitration proceedings shall be preserved.

BY SIGNING THIS AGREEMENT, YOU ARE AGREEING TO SETTLE ANY AND ALL DISPUTES OUTSIDE OF COURT WITHOUT A JURY TRIAL. YOU ARE AGREEING TO ARBITRATE CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT.
Please see a staff member for further explanation of arbitration agreement

Signature of Patient or Guarantor: _____ **DATE: / /**

OFFICE USE ONLY: Witness: _____ **DATE: / /**

NASAL AND THROAT SCOPE PROCEDURE

A patient presenting to our office with sinus, allergy, throat, or voice complaints requires a thorough examination of that specific area. In some cases, this can only be accomplished through the use of an endoscope. This examination is essentially painless and can be performed quickly.

A procedural fee will be submitted to your insurance carrier for this procedure. We will accept your insurance company's allowance for this procedure. You will be obligated to pay any deductible and/or copayments or coinsurances that are applied to this procedure on the claim. PLEASE NOTE: Some insurance companies may list this diagnostic procedure as "SURGERY" on the remittance advice you receive. Please understand all fees are determined by your insurance company and all patient responsibility fees are based on the contract between you and your insurance company.

By signing below, you acknowledge that you have read the above, agree to the procedure, and understand and accept all charges regarding this procedure

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Reason for Visit:_____

Name:_____ **DOB:**_____ **Height:**_____

Drug/Food Allergies: YES NO **List All:**_____

Women Only: Are you pregnant? YES NO **Are you currently breast feeding?** YES NO

PAST MEDICAL HISTORY

AIDS/HIV	Bleeding Disorder	Ear infection	High blood pressure	Snoring
Acid Reflux	Cancer:_____	Eye disorder	Migraines	Thyroid
Allergies	Heart: _____	Gastrointestinal	Neurological	Tonsillitis
Anxiety	Diabetes	Hearing Loss	Lung Disorder	Tuberculosis
Asthma	Dizziness/vertigo	High cholesterol	Sinusitis	Urinary
Autoimmune	Other:_____		Developmental Disorder	STI/STD

SURGICAL HISTORY

Ear Tubes/Ear Surgery Date:_____ Nasal Surgery Date:_____ Sinus Date:_____

Tonsillectomy/Adenoid Date:_____ Heart Surgery Date:_____ Thyroid Date:_____

Cancer:_____ Date:_____

Other Surgery: _____

SOCIAL HISTORY

Alcohol: NONE DAILY WEEKLY MONTHLY SOCIALLY **Smoking/Tobacco**: NONE FORMER CURRENT

FAMILY HISTORY: Please list only immediate family member(s) and label relation as Maternal or Paternal (ex: maternal aunt)

Allergies ☐ Yes ☐ No (Relation/Type): _____

Bleeding Disorder ☐ Yes ☐ No (Relation/Type): _____

Cancer:_____ ☐ Yes ☐ No (Relation/Type): _____

Diabetes ☐ Yes ☐ No (Relation/Type): _____

Heart Disease ☐ Yes ☐ No (Relation/Type): _____

High Blood Pressure ☐ Yes ☐ No (Relation/Type): _____

Thyroid Problems ☐ Yes ☐ No (Relation/Type): _____

Other:_____ ☐ Yes ☐ No (Relation/Type): _____

MEDICATIONS (This includes prescription, over the counter, & vitamins)**- please list ALL current Medications or bring a copy of list**

NAME OF MEDICATION(S)	Dose	How Often & When

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